ARMY GROUND RISK-MANAGEMENT INFORMATION

Countermeasure

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Cold Weather Issue

Countermeasure
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DASAF'S CORNER

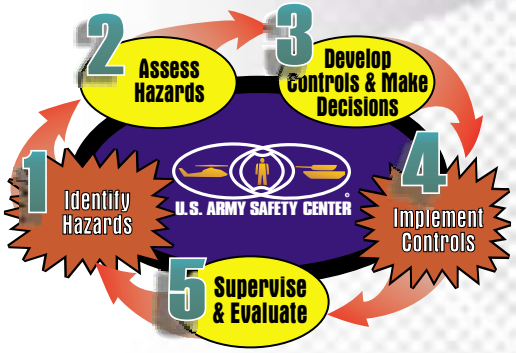
From the Director of Army Safety

Bridging the Gap Between Lack of Experience and Safety Excellence

As we approach the end of this fiscal year, the potential exists for the Army to experience its highest number of accident fatalities since 1994. The Secretary of Defense has laid out a clear challenge for us: **reduce the number of mishaps and accident rates by at least 50 percent in the next two years**. The key to achieving this goal lies in bridging the gap between lack of experience and safety excellence.

Recent deployments to Afghanistan and Iraq have taught me that accident fatalities are not normally the result of an inability to identify hazards. Risk is inherent in combat and realistic training, and our leadership generally identifies the appropriate hazards. However, we do not do as well identifying and implementing the right control measures to mitigate the risk of those hazards.

The cause stems not from negligence or a lack of effort, but rather from a lack of experience and knowledge. LTG Dick Cody, our Deputy Chief of Staff, G-3, asserts that our small-unit leaders and first-line supervisors simply lack the experience necessary to match the mission risks with the identification and implementation of the right control measures. We must bridge the gap between the experience level of our first-line leadership and the knowledge they need to properly mitigate risk. This void can be effectively filled by (1) multi-level leader involvement and dialogue and through (2) knowledge and information-sharing using the Army Safety Management Information System (ASMIS): a soon-to-be fielded web-based aviation, ground, and POV centralized risk-assessment program.



The Way Ahead

DASAF'S CORNER
From the Director of Army Safety

Risk Management "3 Deep" Leadership:

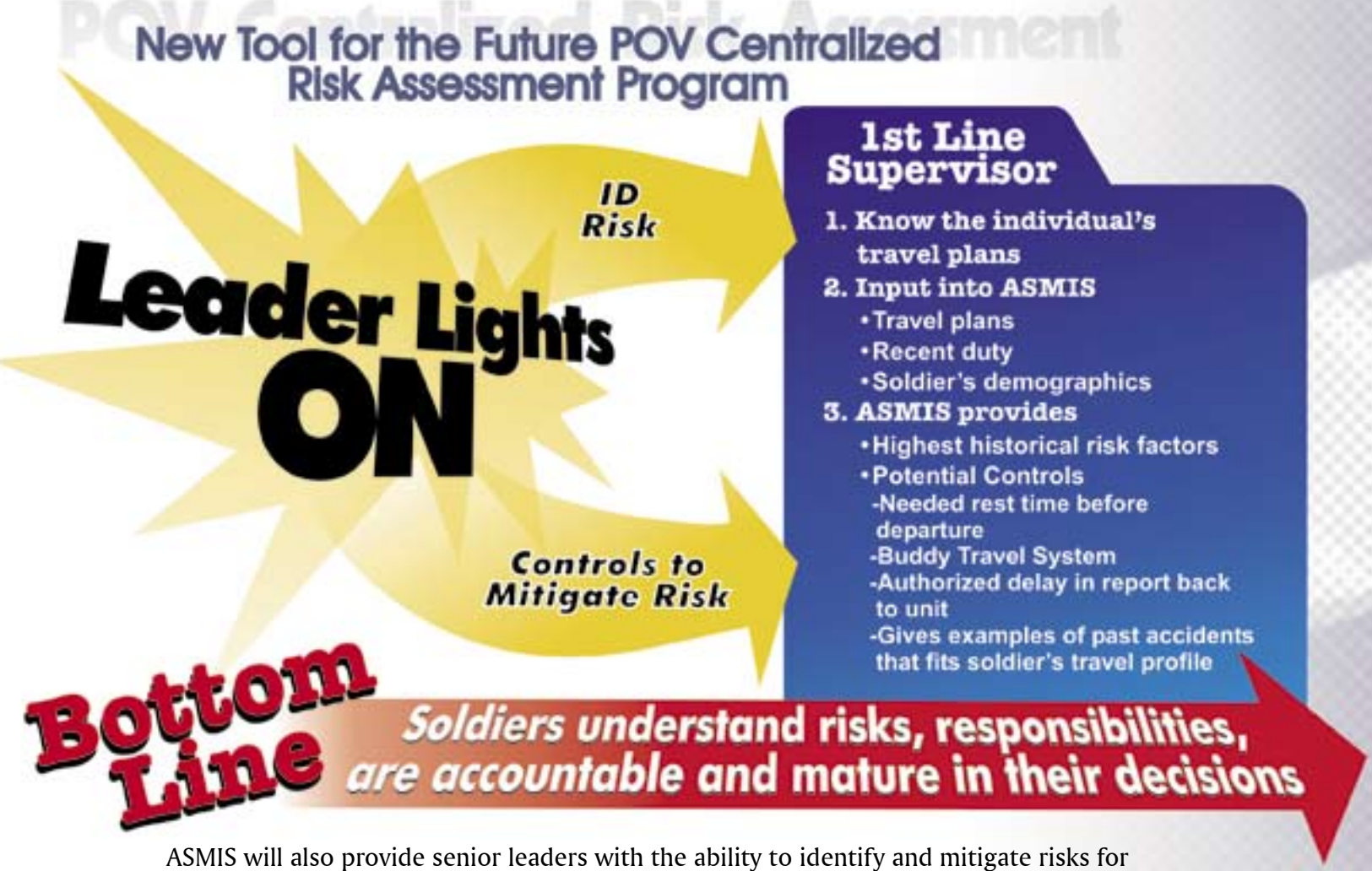
For every mission, on or off duty, there needs to be three levels of leader involvement. Using his knowledge of the individual soldier and guidance from higher levels, the first-line leader interacts face-to-face with each subordinate. The second-line leader supervises and spot checks, providing an independent set of eyes and the higher level of experience. The top-line leader uses his wealth of experience to provide guidance and supervises the risk-mitigation process to ensure the right control measures have been highlighted and implemented. This process of dialogue between leader levels gives less-experienced leaders knowledge in place of experience to protect their soldiers and move toward a safety band of excellence.

Information-Sharing Through Technology:

A second means of bridging the experience gap for first-time leaders is through information sharing that leverages technology. RMIS is our current web-based hazards, risks, and controls database that provides near real-time accident data. As we are transitioning to the next level, the Army Safety Center is developing an automated risk assessment program that incorporates the data found in the RMIS database as well as other "stovepipe" systems to further assist leaders in identifying and implementing effective control measures. ASMIS will be an on-line, centralized risk-assessment program for air, ground, and POVs that will prompt mission leaders to input their demographics, mission type, and experience level. ASMIS will use the Army Safety Center databases to give our soldiers the degree of risk associated with the mission, the hazards, effective control measures, and examples of recent accidents that fit the mission profile.

The capabilities of the POV centralized risk assessment program module of ASMIS will allow a first-line leader—SGT, SFC, PLT LDR, 1SG, etc.—the ability to evaluate a soldier's personal risk profile and subsequently place control measures to mitigate those risks. How does this work? ASMIS will prompt the first-line supervisor to input the soldier's travel plans, recent duty, and demographics into the POV module. ASMIS will respond by highlighting the highest risk factors that are being historically recorded for the soldier's profile. Potential controls to mitigate the soldier's risk level will also be identified: adequate rest needed prior to departure, use of a "buddy" travel system, authorized delayed report-back-to-unit time, etc. Lastly, it

will provide details from recent accidents that fit his or her exact profile. Technology of the ASMIS POV module will facilitate a dialogue between that soldier and his leadership using historial anaylsis. That dialogue will help to ensure the soldier understands the risk and also help develop responsibility, accountability, and maturation of the soldier. We must move into a proactive stance to preserve our combat power.



ASMIS will also provide senior leaders with the ability to identify and mitigate risks for upcoming deployments and combined arms exercises. This knowledge will allow them to develop the most effective home-station and environmental training to mitigate their unit's risk before departure. In the long-term, ASMIS can be integrated into all Army Mission Planning Systems. Wireless technology will allow leaders to obtain real-time information even on long deployments and field exercises. Eventually information on the failure rate of individual pieces of aviation and ground equipment and sub-components will be incorporated into the aviation and ground centralized risk assessment modules' databases.

Using the hazards, risks, and controls information provided by the ground, aviation, or POV modules of ASMIS and supported by 3-deep dialogue between soldiers and their experienced leadership, our less experienced leaders will have the knowledge to properly manage risk.

Keep your leader lights "on!"

Joe Smith

BG Joseph A. Smith

A Warm Tent and a

As I write this article, it's July and I'm in southeastern Alabama where it's hot, hot, hot! But given the literary flash-to-bang time between writing an article and getting it into the bathroom stall where it can be read by soldiers, it's already time to think about winter. It's also the 50th anniversary of the declared cease-fire in Korea, which was a welcome relief to all those dog-faced Joe's who suffered through brutal Korean winters.

A Major Cause of Injuries

Looking back at World War II and Korea, the number of soldiers incapacitated due to cold weather injuries was staggering. LTC (Dr.) Kenneth Orr reported in 1954 that the number of hospitalization days due to cold injuries in those two conflicts was more than 3 million! Imagine our entire Army being hospitalized for more than a week. This stands as a stark reminder of how poorly trained and equipped soldiers can rapidly become compromised, especially in the absence of meticulous supervision by caring leaders.

As a soldier today, you are neither poorly trained nor poorly equipped, nor are you lacking caring leaders. So why bother writing about cold injuries?—because they continue to happen, even though they are preventable. The equipment issued to you, when used and maintained properly, will allow you to fight and win in even the most austere environments.

Personal Experience

I know this because when I was building my little shelter in the snow near Fairbanks, AK, it was 20° F below zero and my gear protected me. And then there was the time I spent the night unexpectedly on a hilltop at the National Training Center (NTC) at Fort Irwin, CA. I was with a light infantry battalion and had nothing but the BDU's I was wearing and my TA-50. Even though the temperature was "only" in the 40's, I endured the coldest night of my life. But this article isn't about "war stories," it's about protecting yourself and the soldiers you work with.

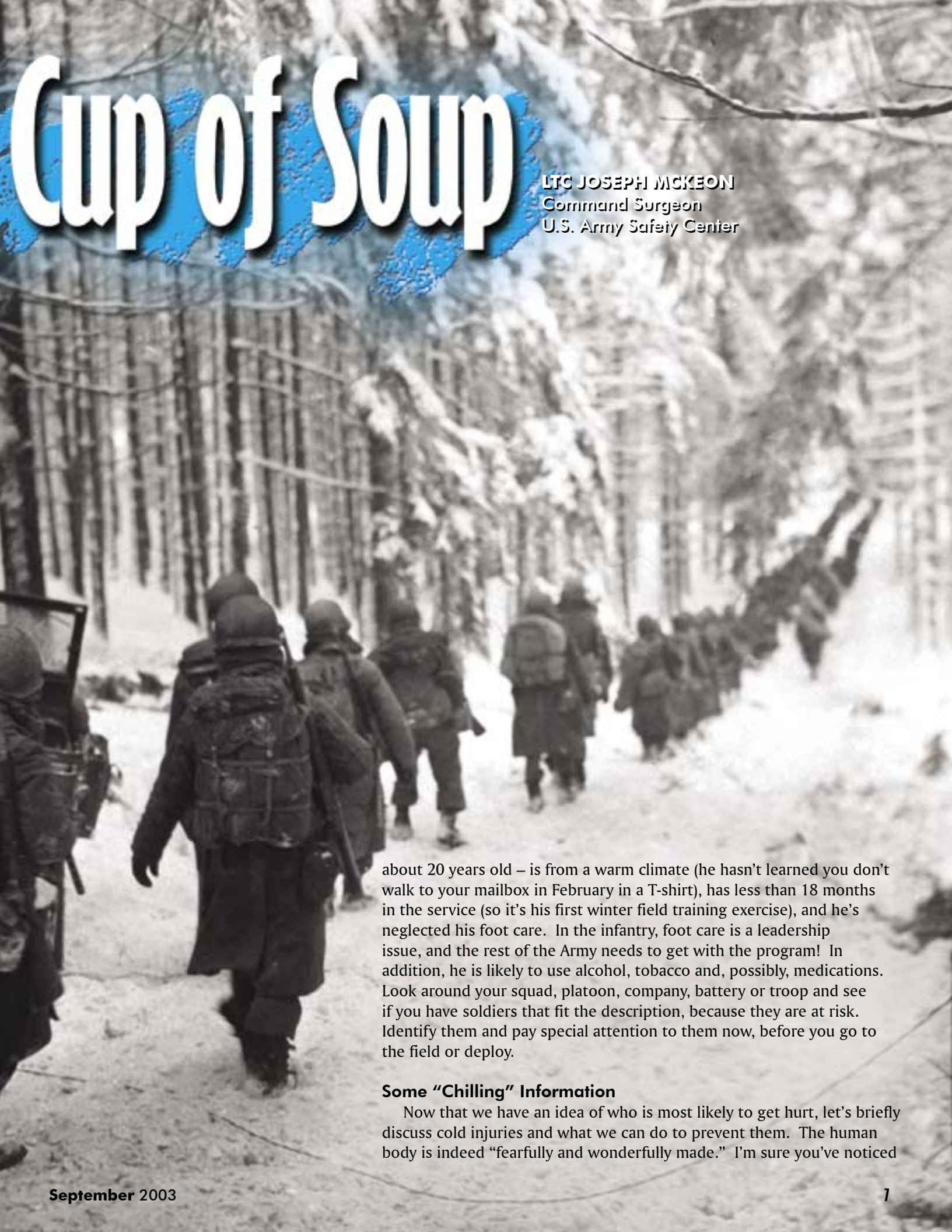
As individuals and leaders, it is your responsibility to ensure your soldiers are properly trained and equipped. That means anticipating being colder and staying longer than originally planned. Those who grew up in cold environments have learned how to respect the weather and dress for it. Few residents of Fairbanks, AK, or Watertown, N.Y., would walk out to the mailbox in a T-shirt and shorts in February, or drive to the store without a coat and gloves in the car. If the door accidentally locked behind you or the car broke down, you could freeze to death. So what was I thinking, ending up with my "hooah" medical team stuck on a hilltop at NTC with no "snivel gear?" The fact is, I WASN'T thinking, and I set us up for cold injuries. Life is too short to make all the mistakes yourself, so learn from others!

The "Typical' Victim

When considering injury prevention, it often pays to target your efforts at the highest risk group. So what does the "typical" cold injury patient look like? He (I'm not using your usual sexist male pronoun; it's just that the typical cold injury victim is male) is young – usually

Cup of Soup

LTC JOSEPH McKEON
Command Surgeon
U.S. Army Safety Center



about 20 years old – is from a warm climate (he hasn't learned you don't walk to your mailbox in February in a T-shirt), has less than 18 months in the service (so it's his first winter field training exercise), and he's neglected his foot care. In the infantry, foot care is a leadership issue, and the rest of the Army needs to get with the program! In addition, he is likely to use alcohol, tobacco and, possibly, medications. Look around your squad, platoon, company, battery or troop and see if you have soldiers that fit the description, because they are at risk. Identify them and pay special attention to them now, before you go to the field or deploy.

Some "Chilling" Information

Now that we have an idea of who is most likely to get hurt, let's briefly discuss cold injuries and what we can do to prevent them. The human body is indeed "fearfully and wonderfully made." I'm sure you've noticed

how some folks get very "red in the face" when they exercise. That's the body's cooling mechanism shunting blood to your skin so the blood can be readily cooled. But did you know the shunting process also works the opposite way? In cold environments, as much as 99 percent of the surface blood flow can be shifted back inside you to keep your vital organs warm. Amazing isn't it?

However, this protective mechanism that has been "engineered" into our bodies can be defeated by what we do. For instance, dehydration decreases the amount of blood that is circulating, thus hindering the body's heating mechanisms. That's why it's so important to ensure we stay hydrated. Pushing fluids can be forgotten in a cold environment. This is especially true if you have to get out of a warm tent when it's below zero, trudge through the snow, and "drop trou" to go to the latrine.

In cold weather, you may be tempted to drink less to reduce your need to leave your nice warm tent. However, this can set you up for dehydration and even a heat injury. That's right, a heat injury! When you are performing hard physical work in a cold environment and wearing all of your protective equipment, it's easy for you to start sweating and become overheated. You can end up exhausted and sweaty, and then rapidly cool off in the cold. It's no wonder the typical cold injury victim is a young, first-term, male soldier. Who usually gets detailed to put up the GP Mediums?!

In addition to the demographics listed above (young, first-term males), there are other significant risk factors. If you have a previous history of cold injuries, you are obviously at risk, because you've already shown that you are susceptible. In addition, if you are not physically fit, you are more likely to be injured; thus the Army's emphasis on physical fitness.

Poor or inadequate nutrition also can quickly take its toll. When you're in a cold environment your body has a greater metabolic demand because you're burning more calories trying to stay warm. If you need 3,000 calories per day in a controlled environment, you may need up to 4,500 calories in a cold environment just to maintain your body weight. Eating meals will also increase water consumption, which will be a hedge against dehydration.

Too little activity also can be a risk factor. While overheating is a risk when you are working hard, lack of activity can cause you to have cold injuries because of poor circulation in the extremities. Using those large muscle groups will ensure good circulation and heating, so get up and do 20 side-straddle hops (when not in contact with the enemy!)

Alcohol and tobacco, as well as caffeine, can also make it harder for you to stay warm. These substances all affect your body's ability to dilate (widen) and constrict the blood vessels, which can defeat your body's built-in heating and cooling mechanisms. Prescription and over-the-counter medications can also adversely affect your body's heating and cooling, so it is important to let your doctor know if you will be exposed to cold weather. If you are a leader, you need to create a healthy work environment where soldiers are steered away from unwholesome behaviors such as tobacco use and excessive alcohol consumption.

Guidelines for Preventing Injuries

OK, let's "wrap this up," so to speak, with some tips on prevention.

- Dress in layers and avoid tight-fitting clothing. This will improve your circulation and provide layers of air between layers of clothing to help insulate you.
- Change your socks frequently to ensure your feet stay dry. This is going to require that you actually take off your boots and socks and change the latter, maybe even the former. If you are a squad leader, you may have to closely observe your soldiers to ensure compliance.
- Beware of the wind. Wind chill can cause skin to freeze at temperatures that would be much less dangerous were there no wind. This is especially important when you are working around helicopters, or in open areas where trees or man-made features are not available for wind protection.
- Protect your face and ears; these areas often suffer frostbite because of exposure and decreased blood flow. Wear the appropriate gloves, especially when you're handling petroleum, oil, and lubricant products, and avoid touching cold metal or fuel.
- Eat often and drink warm, non-caffeinated beverages. Soup is super!
- Use the buddy system. Seek medical attention for yourself and your buddy before symptoms become severe. As cold skin gets numb, subtle damage can progress and become a severe injury. Don't be like those thousands of soldiers that spent weeks convalescing during World War II and Korea.

This Army needs every soldier, every day, so take care of your body. After all, where else are you going to live?

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Cold Hurts

COLD HURTS

JULIE SHELLEY
Staff Editor

A popular motivational anecdote goes something like this: "That which does not kill you makes you stronger." How many times have you heard that one? While this oft-quoted line might have some fundamental truth, it forgets to mention that those things that don't kill you often hurt a lot.

Cold-weather operations present many hazards that, if not approached correctly, can lead to disaster: severe cold injuries, carbon-monoxide poisoning, and tent fires, just to name a few. But, the winter environment also introduces other, not-so-serious risks that can increase pain and decrease productivity. These minor aches and pains are not only a nuisance; they are also costly in terms of lost man-hours and dollars.

Fortunately, most cold injuries are completely preventable if appropriate precautionary measures are taken. But sometimes even the best-prepared soldier can fall prey to one of the "minor" injuries listed below. Be on the lookout for these symptoms and seek the proper medical treatment if you or one of your soldiers exhibits any of the following.

Frostnip

This type of injury, along with more serious ailments such as frostbite, can occur anytime the air temperature is below freezing (32 °F or 0 °C). Frostnip is caused by freezing of the skin's upper layers. In exposed skin, the risk of a freezing injury increases with higher wind speeds.

Frostnipped skin will appear red and possibly swollen. Although painful, frostnip generally is limited to the skin's surface—the face, ears and extremities being particularly vulnerable—and causes no further damage after the affected area is re-warmed. However, repeated frostnip in the same spot can dry and crack the skin, making it very sensitive. It also is important to note that distinguishing between frostnip and frostbite can be very difficult. Frostnip must be taken very seriously and all frostnip injuries should be reported immediately.

Frostnip vs. Frostbite Can You Tell the Difference?

Frostbite is tissue damage resulting from ice crystals forming within or between cells in the body. It is more common at higher altitudes, especially if core body temperature is low (i.e., hypothermia). The affected area (usually an extremity or the ears, nose, or face) becomes cold, hard, white, and numb. When warmed, the skin becomes blotchy red, swollen, and painful.

Blisters often will form in 4 to 6 hours, helping to distinguish frostnip from frostbite. (Frostnipped skin often will peel like a sunburn, but takes 24 to 72 hours to do so.) If the blisters from frostbite are filled with clear fluid and are near the tips of the digits, they usually will heal without significant residual damage. However, if the blisters are filled with blood or pus, significant tissue damage or gangrene is likely. Get any soldier with these symptoms to medical care ASAP!

Much of the tissue damage resulting from frostbite occurs during re-warming, so it is critical that re-warming take place after the soldier is stable. If a soldier has to walk after suffering a frostbite injury to the feet, do NOT re-warm the affected area until after he gets where he needs to be—further tissue damage in this situation is inevitable due to the trauma of walking.

Immediate warming can be accomplished in the field by placing the frostbitten extremity in warm water (not to exceed 105 °F—this temperature is tolerably warm to the soldier providing care). Keep in mind that the injured soldier's extremity is numb. Bandage the injury in a sterile dressing from a first-aid kit and minimize trauma to the affected area during evacuation. And remember to push fluids, as the soldier probably is dehydrated.

Sunburn

You don't have to be in the desert or at the beach to get sunburned—the threat of sunburn depends on the intensity of sunlight, not air temperature. Add in snow, ice, and lightly colored objects, all of which reflect the sun's rays, and the scene is set for a major sunburn injury if you're not careful. Sunburned skin will be painful and hot to the touch, appear red, and possibly could be swollen and blistered. With the potential to last for hours or even days, sunburn also can cause temporary incapacitation and increases heat loss during cold exposure.

To prevent sunburn anytime of year and in all environments, use sunscreen with a sun protection factor (SPF) of at least 15 and cover all exposed skin. In cold weather, sunscreen should be alcohol-free. (The Army has available an alcohol-free sunscreen that can be purchased under NSN 6505-01-121-2336). If you or another soldier should become sunburned, prevent further exposure and apply a moisturizing lotion; aspirin or acetaminophen may be given for pain. Soldiers with large areas of injured or blistered skin should be evacuated for medical treatment.

Snow Blindness

Snow blindness, like sunburn, is a threat posed by the intensity of the sun's rays, not the temperature outside. Solar radiation can "sunburn" unprotected eyes, leading to snow blindness. Symptoms of snow blindness include painful, gritty eyes with profuse tearing, blurred vision, and possibly, a headache. Soldiers suffering from snow blindness should be removed from direct sunlight and allowed to rest in a dark area with their eyes covered by cool, wet bandages until they can be evacuated. Bacitracin or erythromycin ophthalmic ointment also should be applied.

Protective eyewear or goggles that block at least 90 percent of ultraviolet radiation can help prevent snow blindness, and sunglasses with visible light transmittance in the 5- to 10-percent range are needed to reduce the sun's reflection off snow. In addition to protective eyewear,

sideshields or deeply wrapped lens designs should be used to reduce the chances of eye injury. It should be noted that not all commercially available sunglasses block enough solar radiation to protect against snow blindness. Polarized sunglasses purchased under NSN 8465-00-161-9415 will provide the proper sun protection needed in a winter environment.

Dry and Chapped Skin

The combination of sun, wind, snow, rain, and low humidity can wreak havoc on your skin, lips, nose, mouth, and throat. Nosebleeds, sore throat, minor respiratory difficulties, and chapped skin are all common ailments seen in the winter environment. To prevent nose and mouth irritation, cover the bottom part of your face with a balaclava or scarf. Chapped lips and skin can be prevented by using lip balm (NSN 6508-01-277-2903) and limiting skin exposure to the elements. To help the skin retain water, use a skin moisturizing lotion. Petroleum jelly on the lips and nostrils can help prevent dryness and chapping.

Slips and Falls

Operations in cold weather generally see an increase in slips and falls, as well as vehicle accidents. Paths, walkways, and roads are frequently muddy or frozen. Also, heat escaping from the entrances of tents and buildings causes cycles of thawing and freezing of the ground surface, making those areas particularly hazardous. Add to the mix fatigue, bulky clothing, and vision-restricting hoods and hats, and the danger becomes very real.

To reduce the risks posed by slippery, frozen surfaces, snow should be removed from the ground *before* tents are set up. Slippery paths and walkways should be marked with warning signs. Finally, sand, salt, ashes, or straw should be spread on known and potentially hazardous areas to increase traction.

Tent Eye

Tent eye is an inflammation and irritation of the eyes resulting from exposure to fuel flames—most commonly in poorly ventilated shelters where stoves and heaters are being used. Rubbing itchy eyes caused by these fumes subsequently can lead to an infection. Anyone suspected of having tent eye should be moved to fresh air and taken to a medical facility for evaluation and treatment.

Burns

Stove and heater use sets the perfect environment for burns if soldiers are not trained properly in their use. Contact with hot surfaces and fires or the explosion of stoves and fuel sources can cause a multitude of burn injuries. In addition, improper fueling and lighting techniques or inadequate ventilation can result in the accumulation of flammable fumes. If these fumes are ignited accidentally, potentially fatal fires can occur.

Anyone who has been burned should be taken from the heat source. Burning or smoldering clothing should be removed unless it sticks to the wound. The wound itself should be covered with a dry, sterile dressing tied at the edge of the burn, not over it. DO NOT apply ointments, ice, or snow to the burn, and never break blisters.

Injuries stemming from the use of stoves and heaters are preventable if the correct safety measures are taken. Only properly trained soldiers should be permitted to set up, light, refuel, and maintain stoves. A fireguard should be posted anytime a stove or heater is being used, and horseplay should be prohibited inside the shelter. Air intake to the stove or heater should not be blocked, and the stovepipe should be tall enough to draft properly and be kept clean of soot and debris. Shelters and tents should not be sealed so tightly that ventilation is blocked completely. Lastly, tent and shelter doorways must be kept clear at all times to allow for easy escape should a fire break out.

Remember that it's up to you when it comes to cold weather safety. The environment can't be controlled, but the risks associated with it can. Be prepared and think ahead about the small stuff!

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Article compiled from material found in Technical Note TN/02-2, *Sustaining Health and Performance in Cold Weather Operations*.

A Long Winter's Night

CW2 KEVIN MITCHELL
1/6 Cavalry
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Republic of Korea

As the winter months approach, the days get shorter, the nights get longer, and they both get much colder. However, this does not keep the Army from training—and field training exercises (FTXs) are a reality for every unit, no matter how cold it is. Just as surely as the temperature drops, soldiers look for ways to stay warm. I'd like to tell you a story about what happened to my troop and an M1941 "potbelly" stove one February night during a 2-week FTX.

According to our local standard operating procedure (SOP), a fireguard is required anytime a stove is being used. This is a good idea and a great safety measure. However, it's hard to do when you are part of an air cavalry troop that generally consists of only 30 to 35 soldiers, most of which have Army-regulated crew rest issues. On this particular night the maintainers, which made up approximately half the troop's personnel, were in their own GP Medium tent while the rest of us—the pilots—were in a separate tent.

At the beginning of the FTX our safety officer reinforced the necessity of a fireguard at night while everyone was sleeping. The pilots dismissed him because none of us (including myself) wanted to stay awake all night, or even for just a few hours, working the fireguard shifts. The commander also erred against safety and established policy by not enforcing the fireguard issue. He wanted every pilot available for whatever missions came down the following day.

We'd been set up in our area of operations (AO) for about 4 days and everything was going well. But, on that fourth day, it got exceptionally cold. Using the M1941s wasn't even in question—the only question was how high, or hot, were we going to have the stove? Keep in mind this was before I knew the concepts of "risk assessment" and "risk management matrix." Nevertheless, we applied part of the risk management process and implemented some controls by deciding to maintain the stove at its lowest setting. We then attempted to keep the heat from the stove inside the tent by sealing it up, including the doors and one of the two top vents. Soon after, we all went to sleep.

Around 0100 a couple of us woke up because it was freezing inside the tent. We noticed that the stove didn't appear to be giving off as much heat as it was earlier in the evening. We didn't know why, and since it was cold and in the middle of the night, we didn't stop to think about it. Instead, we did three things. First, we closed the other vent on the top of the tent, leaving us with no ventilation except for the stovepipe. Second, we turned the stove up to the halfway point. Lastly, we went back to sleep without a care in the world. No problem, right?

Well, about an hour later the same thing happened with the stove. It just wasn't putting out any heat. So, without thinking about what could be causing the problem, we turned the stove up to the max and went back to sleep. Still no problem, right?

Around 0400 one of the officers in the tent woke up and sensed that something just wasn't right. He grabbed his flashlight and shone it around. To his surprise, all he saw was about 5 to 6 feet of smoke engulfing the whole tent. He immediately woke everyone else, and we took the appropriate actions to eliminate the problem. We immediately turned off the stove and opened the doors and vents to allow the tent to air out. Fortunately, we averted having a disaster.

Three separate and distinct things led to this situation. To begin with, the stove wasn't on a flat surface. This fact was known during the initial setup, but when the squadron commander tells you to set up at a certain place, you set up at that place. Plus, who wants to move a GP Medium after it is set up? To alleviate the problem, a wooden stake was wedged under the stove to level it and keep it from wobbling. However, sometime during the previous 3 days, the stake was accidentally moved from its position, allowing the stove to sit at an angle. This caused some of the fuel to pool on one side of the stove, resulting in incomplete combustion. The incomplete combustion caused the smoke that eventually filled the tent. It also was determined that our only source of ventilation, the stovepipe, was clogged and didn't allow the exhaust to escape properly. Add that to the closed doors and vents, and the problem was compounded.

The commander, as well as the warrant officers, failed to see the potential risk in leaving the stove burning without supervision. I was taught in the Aviation Safety Officer Course that for every incident with a serious result, there are 59 minor injuries and 600 near-misses. The actions of those involved in my troop could be considered to have resulted in a near-miss—a major one! That FTX could have ended tragically, but thankfully it didn't.

The moral of the story is that there are no valid reasons in the training environment to overlook or ignore any safety control. In this situation, the commander should have been willing to accept the loss of a pilot or two each day for the length of the FTX to pull fireguard duty. The other option was for the commander to accept the risk of the elements and tell us to bundle up and prepare for a long, cold night.

I tell this story to bring some awareness to the hazards of not adhering to the proper controls. Safety measures provide a means to protect the military's most treasured asset—the soldier. Enforce the standard!

Contact the author at kevin.dewayne.mitchell@us.army.mil.

Seven Tent Stove Safety Tips

1. Always do your preventive maintenance checks and services before using a tent stove.
2. Listen to the tips you get from your safety personnel and those you hear during your classes and lectures.
3. Always have a fireguard on duty, even if it means doing 1 hour shifts.
4. Make sure that someone has read the technical, field, or operator's manual(s) for the tent stove you are using.
5. Make sure the tent is always vented.
6. Always make sure the stove is level.
7. Only use approved fuels.

The ABCs of Suicid

LTC JERRY SWANNER
General Staff
Department of the Army Personnel
Human Resources Policy

A young soldier who ran his unit's arms room fell in love with a female officer. She made it clear that she could not have a romantic relationship with the young soldier. Despondent, he went to the arms room, took an M-16 from the shelf, loaded it, and shot himself in the head. During the many years that have passed, I often have wondered about that soldier and the things he missed in life. There would have been another girl; one failed relationship was not worth ending his life. In a moment when he wasn't thinking clearly, he chose a permanent answer to a temporary problem. Suicide is the worst answer to life's problems, but it's a choice some soldiers continue to make. (The editor)

Between 1997 and 1999, Army suicides increased by 27 percent. In 2000, the Army Chief of Staff (CSA) called suicide a "serious problem" and directed a complete review of the Army Suicide Prevention Program (ASPP). He called for a campaign that would refine the ASPP, making use of the best-available science and increasing awareness and vigilance. He further stated that for the program to be effective it must involve leaders, be proactive, and provide improved training and education.

The offices of the Army G-1, Army Surgeon General, and Chief of Chaplains began evaluating the existing program and later recommended some refinements, which they briefed to the CSA. Although many of the existing program's original concepts were kept, there was a new emphasis that incorporated the CSA's guidance. That guidance evolved into four "pillars" intended to help reduce suicides. Those pillars are:

- Develop positive life-coping skills.
- Encourage help-seeking behavior.
- Maintain constant vigilance.
- Integrate and synchronize unit and community suicide prevention programs.

These refinements were approved, and the campaign to use these changes began in 2001. Coupled with a renewed command interest in suicide prevention, the campaign contributed to the Army's lowest suicide rate on record in 26 years. However, the ASPP would suffer its toughest challenge following the events of 11 September 2001. Increased operations tempo (OPTEMPO), deployments, combat operations, and uncertainty have

increased stress for soldiers and their families. Army suicide rates now are climbing closer to the rates seen in the late 1990s. However, despite the increased stress, those units that have remained focused on their suicide prevention programs have been able to reduce suicides.

When it comes to saving lives there are many key roles, all of which are vital. These roles are founded upon the basic suicide prevention principles of:

- Recognizing anyone can be at risk for suicide.
- Involving various installation and local community support agencies.
- Believing that most suicides can be prevented.
- Trusting that leadership and training can make a difference and save lives.

Now we'll take a closer look at those roles and give you some checklists to help reduce the suicide risk within your organization.

de Prevention part 2

All soldiers:

- If you are having a tough time with a personal relationship, financial hardships, think that you are drinking too much, or feeling depressed, talk to someone. Talking to friends, family, "battle buddies," or a trusted agent such as a chaplain or counselor about your problem(s) is a sign of maturity.
- If you ever reach a point in your life when you are thinking about hurting yourself—STOP! Save yourself by seeking help immediately! Do not allow a temporary problem or situation to ruin (or possibly end) your life.

"Buddies":

- Know the warning signs of suicide, including the leading "triggers" or losses that can lead soldiers to consider or commit suicide.
- Take immediate action when you suspect someone is suicidal or when a person admits they are contemplating suicide.
- Become aware of local support services and how they can provide help.

First-line supervisors and leaders:

- Know when your soldiers and employees are facing a life stressor. Recognize when their behavior or performance has changed.
- Assess each of your soldier's life-coping skills and seek opportunities to positively influence their behavior.
- Ensure your soldiers are trained properly in suicide prevention and awareness.
- Create an atmosphere of inclusion for all—never ostracize anyone.
- Know the potential triggers for suicide.
- Know the potential warning signs of mental illness.
- Promote the use of available support services.
- Reduce the perceived stigma regarding behavioral health.

Commanders:

- Ensure your unit ministry teams (UMTs) are aware when a soldier is facing marital or relationship problems, the loss of a loved one, pending Uniform Code of Military Justice (UCMJ) actions or separation, or financial hardships.
- Ensure all newly assigned soldiers are aware of the location of installation support agencies and know how to get help through them.
- Conduct officer and noncommissioned officer professional development (OPD and NCOPD) training that focuses on aspects of mental health.
- Ensure that your UMTs have received formal suicide prevention training. This training can be conducted in conjunction with the new Army Suicide Prevention Training Program.
- Ensure that all UMT members have been through the Living Works Applied Suicide Intervention Skills Training (ASIST) 2-day workshop. Ensure that all leaders understand how to use ASIST-trained individuals to determine the risk of suicide for their soldiers.
- Promote help-seeking behavior as a sign of strength.
- Develop well-defined procedures for registering and storing privately owned weapons.
- Know if your soldiers have access to personal firearms at their place of residence.

• Ensure any guardsmen or reservists attached to your unit for deployment have received suicide prevention training before deployment.

• Limit the use of the "command interest profile" (formerly known as the "suicide watch"). Only use under the advice of a behavioral health professional or when local emergency services are not available.

UMTs:

• Become ASIST T-2 trained.

• Attend formal suicide prevention and awareness training offered through the Office of the Chief of Chaplains.

• Download the U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM) *Resource Manual for Suicide Prevention*.

• Keep your commander informed on current suicide statistics and demographics. Explain the high-risk categories to commanders.

Behavioral health professionals:

• Ensure your 91X's (mental health specialists) are ASIST T-2 trained.

• Work closely with chaplains when addressing the overall welfare of soldiers under your care.

• Offer OPD and NCOPD classes on basic mental health.

• Pursue opportunities to make services and counselors more available and accessible.

Installation suicide prevention standing committees

• Establish a suicide prevention program specifically tailored for your installation.

• Help the installation and local commanders implement their suicide prevention programs.

• Track the percentage of all assigned chaplains who have received formal suicide prevention training.

• Ensure that commanders and senior NCOs are aware of local support agencies and how to refer soldiers who need help.

• Ensure there are enough behavioral health personnel to meet the needs of the installation and that someone is always available for crisis intervention or assessment.

• Ensure that commanders are provided timely feedback from support agencies concerning the effectiveness of their soldiers' treatment.

• Encourage stress management programs for soldiers and family members, especially during times of increased OPTEMPO or deployments.

• Track the number of ASIST T-4 and T-2 level crisis intervention-trained personnel on post.

• Review and publicize emergency procedures available to all soldiers and family members, such as crisis hotlines and suicide awareness cards.

• Ensure newly assigned soldiers are briefed on installation support agencies during in-processing.

• Ensure dependent school personnel are trained to identify and refer for help individuals at risk for suicide.

• Establish procedures for creating and using an installation suicide response team or other critical event debriefing team.

To help you implement the Army's new Suicide Prevention Campaign, the Army G-1 has formed a team of chaplains and behavioral health professionals that are available for staff assistance visits. These visits range from conducting formal suicide prevention training to junior leaders, major subordinate command commanders, and command sergeants major, to consultation visits with installation suicide prevention committees. To arrange a staff assistance visit contact the ASPP manager, LTC Jerry Swanner, at jerry.swanner@hqda.army.mil or call him at (703) 614-7946, DSN 224-7946.

ACV

Class A

■ A soldier was killed when the M113 he was driving threw a track and overturned. The M113 had crossed over a drop-off on the opposite side of the road just prior to the accident.

■ A soldier was killed while performing gunner duties on a Light Medium Tactical Vehicle (LMTV). The LMTV had been participating in a four-vehicle combat patrol when it veered off the roadway and overturned in a gully, resulting in fatal injuries to the gunner. The soldier driving the LMTV was injured in the accident.

AMV

Class A

■ One soldier was killed and three others were injured when the driver of the government-owned vehicle they were riding in lost control and struck a ditch. The driver reportedly swerved to avoid a civilian vehicle.

Personnel Injury

Class A

■ A soldier drowned in a lake while wading. The soldier's unit began searching for him after he was reported missing and found his body in the lake the next day.

■ A soldier was participating in the Army Physical Fitness Test (APFT) when he collapsed at the end of the 2-mile run. He was pronounced dead at a local hospital.

■ A soldier collapsed during a monthly physical training (PT) formation run and lost consciousness. The soldier was initially revived, but later died at a local hospital.

■ A soldier died after suffering a heart attack during the walking portion of the APFT.

■ A soldier suffered a permanent total disability after suffering heat stroke during a 4-mile squad PT run. The soldier was placed on a respirator due to his injuries.

Class B

■ A soldier's hand was amputated when a grenade detonated during a unilateral team training exercise at an established range. Another soldier suffered very serious injuries in the accident.

Class C

■ A soldier suffered severe sunburn after a day at the beach. The soldier had participated in extensive water activities, including jet skiing, and failed to reapply sunblock after leaving the water.

POV

Class A

■ A soldier was killed when he attempted to pass a vehicle on his motorcycle and collided with an oncoming car. The civilian driver of the oncoming vehicle was not injured.

■ A soldier was killed in a multi-vehicle accident while driving his privately owned vehicle POV.

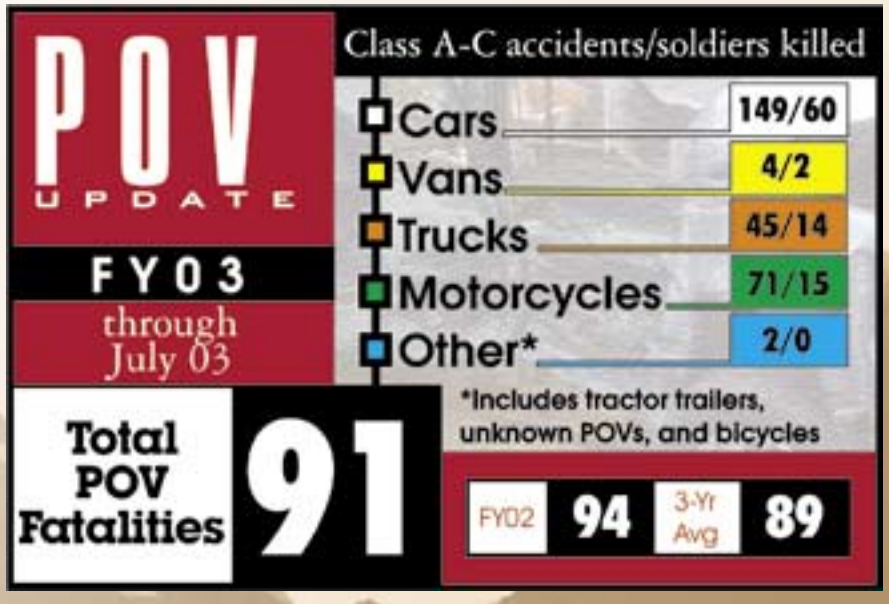
■ Two soldiers were killed when their POV left the roadway and entered a slough. The driver of the vehicle apparently lost control just prior to the accident, resulting in fatal injuries to himself and his passenger.

■ A soldier was killed when his motorcycle was struck by another vehicle at an intersection. The civilian driver of the vehicle, who was not injured, had run a red light and hit the soldier.

■ A soldier was killed when his motorcycle hit a concrete barrier at a high rate of speed. The soldier, who was on leave at the time of the accident, apparently lost control of the motorcycle prior to hitting the barrier.

Class C

■ A soldier suffered fractures to his leg when he was thrown from his motorcycle. The soldier was riding with a group of other riders at dusk on unfamiliar roads when he lost control of his motorcycle while going around a corner.



Seven Years' Bad Luck

Countermeasure, July 2003

There is no such thing as an "unloaded" gun, and memories last a lifetime—not just 7 years. This article created some sad flashbacks that reminded me of a violent death in the barracks. A military policeman had been cleaning his weapon when it went off and killed him.

I knew this soldier personally. He came to the clinic regularly to visit one of our military sanitarians. His partner dated our babysitter, who lived next door, when they were both in high school. When I saw that MP lying there, he wasn't just a statistic—he was someone I knew.

Commanders, NCOs, and civilians in this Army all care about soldiers. We have risk assessments and health hazard risk assessments, but the bottom line is, "What's best for the soldier's safety?" That doesn't include a soldier getting killed with his issued weapon.

There is no such thing as an "unloaded" gun. Check and re-check weapons because the disaster (of an accidental discharge) doesn't just affect the victim. When a soldier takes a risk and is injured or killed, there is a ripple effect. Commanders, fellow soldiers, family members, and civilians are impacted—forever.

Ron Reiland
Fort Lee, VA

I have a story to pass along regarding "unloaded" weapons. I had nearly the exact mishap the editor related in his story, "Seven Years' Bad Luck." I have the same pistol and was about to clean it, just as in the story. The difference was that I did pull the slide back to clear the chamber before pulling the trigger to release the firing pin.

My mistake was that I neglected to look into the chamber to ensure the weapon was empty. The extractor had not pulled the last (unfired) round from the chamber and when I pulled the trigger, the bullet went through a sliding glass door. I was 18 years old at the time and considered myself fortunate that the damage was limited to the door. I had to pay my father for the door after the accident, but I have always thought the cost of the door was a cheap way to learn a valuable lesson. I hope that sending this story to you can help someone else avoid making the same mistake.

SFC Mark Heidemann
Wisconsin Army National Guard

SFC Heidemann,

Thanks for sending in your comments. You brought out a very good point. If you pull back the slide or bolt and don't see a casing or cartridge come out of the ejection port, it's easy to assume the chamber is empty. However, that can be a very dangerous assumption. Extractors can weaken or break and fail to remove an unfired cartridge. I had that experience with a military surplus Ballester Molina .45 ACP pistol. When fired, there normally was enough pressure to cause the case to back out of the chamber, hit the extractor, and come out the ejection port. However, when the action was manually cycled, the broken extractor would just slip off the rim of the unfired cartridge and leave it in the chamber. If I hadn't visually inspected the chamber, I could have had an accidental discharge with a .45—and those slugs make BIG holes! The bottom line is that a weapon is not safe until you have personally inspected the chamber to ensure it is empty. (The editor).

I Am Still Here
Countermeasure, July 2003

Editor's Note: The author of this article, MSG Shane Curtis, received these e-mails in response to his story, "I Am Still Here."

First, I want to commend you on your resilience and tenacity to overcome such a tragic event. For many, it would surely have been more than they could surmount.

My primary reason for writing, however, is to thank you for sharing such an "eye-opening" story. I am still a fairly novice (3 years' experience) motorcycle rider and though I regularly use a helmet, on occasion I am tempted to "just run up to the store" without it. Your story helped remind me that, in AN INSTANT, your life can be forever changed.

I constantly reinforce the use of bicycle helmets to my two young children. You have reinforced to me that not only is (my) using a helmet a good example for them, but also the right thing to do!

Capt. Ferdinand Garcia
Ohio Army National Guard

I just finished reading your story about the motorcycle accident you had, and all I can say is, God bless you! You know you had someone looking out for you that day! I am very glad to read that everything is fine with you; and a little memory problem seems to be a small price to pay for having your life.

It's just common sense, I think, to wear a helmet when you're riding a vehicle where your entire body is at the mercy of whatever accident you might get into. Your head, especially, is nothing to take chances with. I am sure your article will save many lives. Good luck and God bless.

Ms. Barbara Goode
Aberdeen Proving Grounds

Our Oops!

We recently received an e-mail from LTC William Duddleston of Fort Leonard Wood, MO., regarding the "Fluid Replacement Guidelines for Warm Weather Training" chart on page 7 of our July issue. LTC Duddleston accurately pointed out that "Field Assaults" should be listed under "Hard Work" rather than "Moderate Work." The contradiction was between what was published in Government Training Aid (GTA) 05-08-012, dated 2 December 2002, (cited by LTC Duddleston); and Technical Bulletin Medical (TB Med) 507, dated 7 March 2003, which we cited in our chart. We were unaware of that contradiction and are working to correct that discrepancy.

In the meantime, soldiers and their leaders can check out the U.S. Army Center for Health Promotion and Preventive Medicine's Web site at: **http://usachppm.apgea.army.mil/doem/pgm34/HIPP/WorkRestTable.pdf** for work/rest information.

We appreciate the fact that LTC Duddleston cared enough about the proper hydration of his soldiers to bring this to our attention. In the "DASAF's Corner" published in the August *Countermeasure*, BG Joseph Smith closed his article by saying, "I ask you to keep your leader lights 'on' and be the leader who prevents the next accident." This is a good example of having your leader lights "on."

Your responses to the stories in this magazine let us know that we are reaching people with our safety message. If you read an article in *Countermeasure* and want to share your thoughts or personal experiences, please e-mail me at robert.vanelsberg@safetycenter.army.mil


When using cold-weather clothing, remember
C O L D :
Keep it...Clean
Avoid.....Overheating
Wear it...Loose in layers
Keep it...Dry
U.S. ARMY SAFETY CENTER